# 香 港 醫 務 委 員 會

# The Medical Council of Hong Kong

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## DISCIPLINARY INQUIRY
## MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHOW Heung Wing Stephen (周向榮醫生) (Reg. No.: M03960)

Date of hearing: 15 February 2023 (Wednesday)

Present at the hearing

Council Members/Assessors: Prof. LAU Wan-yee, Joseph, SBS
(Chairperson of the Inquiry Panel)
Dr CHAN Yee-shing
Dr CHUNG Wai-hung, Thomas
Mr HUNG Hin-ching, Joseph
Ms HO Yuk-wai, Joan

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Graham HARRIS, SC and
Ms Yasmine ZAHIR as instructed by
Messrs. Liu, Chan and Lam, Solicitors

Senior Government Counsel (Ag.) representing the Secretary: Miss Liesl LAI

The Defendant is not present.

1. The amended charges against the Defendant, Dr CHOW Heung Wing Stephen, are:

*"That, he, being a registered medical practitioner:*

*(a) was convicted at the High Court on 12 December 2017 of the offence of manslaughter, which is an offence punishable with imprisonment, contrary to Common Law and punishable under section 7 of the*

*Offences against the Person Ordinance, Chapter 212, Laws of Hong Kong; and*

*(b) has been guilty of misconduct in a professional respect in that he failed to report to the Medical Council the conviction mentioned in paragraph (a) above within 28 days of the conviction, contrary to section 29.1 of the Code of Professional Conduct published in January 2016."*

**Facts of the case**

2. The name of the Defendant has been included in the General Register from 10 July 1980 to the present. His name has never been included in the Specialist Register.

3. The Defendant was originally tried together with 2 other defendants, namely, CHAN Kwun-chung ("CHAN") and MAK Wan Ling ("MAK"), each facing one count of manslaughter, contrary to the Common Law and punishable under section 7 of the Offences Against the Person Ordinance, Chapter 212 of the Laws of Hong Kong. After a trial which took 100 days in 2017, the jury found the Defendant and CHAN guilty of manslaughter on 11 December 2017. On 18 December 2017, the Defendant was sentenced to imprisonment for 12 years.

4. The Defendant lodged an appeal against his said conviction and sentence. On 4 November 2021, the Court of Appeal unanimously dismissed the Defendant's appeal against conviction. However, the Defendant's appeal against sentence was allowed to the extent of reducing his sentence from imprisonment of 12 years to 10 years.

5. The Defendant later applied to the Court of Appeal for leave to appeal to the Court of Final Appeal but was refused on 23 February 2022. His application to the Court of Final Appeal for leave to appeal was also refused.

6. By his application form for Annual Practising Certificate for 2018 dated 16 January 2018, the Defendant first informed the Registrar of Medical Practitioners of his said conviction. He also indicated on his application form that "*the conviction has not been reported to the Medical Council [the"Council]*".

7. In support of the Secretary's case, the Legal Officer also relies on the following court documents relating to the Defendant, copies of which are placed before us for our consideration:-

(1) Extracts from the transcript of proceedings at the trial of the Defendant, CHAN and MAK;

(2) Reasons for Sentence by Mrs Justice BARNES dated 18 December 2017;

(3) Judgment of the Court of Appeal in *HKSAR v Chow Heung Wing Stephen & Another* [2021] HKCA 1655 dated 4 November 2021; and

(4) Judgment of the Court of Appeal in *HKSAR v Chow Heung Wing Stephen & Another* [2022] HKCA 313 dated 23 February 2022.

8. The factual background of the offence of manslaughter, for which the Defendant was found guilty by the jury, was neatly summarized by the Court of Appeal in its Judgment dated 4 November 2021:-

> "*4. In February 2012, the "DR Group" launched a cellular therapy treatment, known as "CIK" or "AI" or "CIK/AI" treatment, whereby blood was to be extracted from a human body and taken to a laboratory, Asia Pacific Stem Cell Science Ltd ("APSC"), to undergo a particular process of culturing, after which it would be transfused back into the same human body…*
>
> *5. The CIK treatment was received by various customers, including* [redacted] *("the deceased"), who had her blood drawn on 12 September 2012 at a clinic of the DR Group known as the Mesotherapy Clinic ("Mesotherapy"), which was then processed at APSC. Unfortunately, her blood became contaminated during the processing stage before it was infused back into her body on 3 October 2012, as a result of which bacteria were introduced into her bloodstream. She was subsequently admitted to the Intensive Care Unit of Ruttonjee Hospital on 4 October 2012 for emergency treatment, but tragically died on 10 October 2012; the cause of death being "multi-organ failure", caused by mycobacterium abscessus septicaemia.*

6. *The prosecution alleged that CIK treatment was experimental in nature (for trial in cancer patients only) and, accordingly, wholly inappropriate and unnecessary for administration to a healthy human being such as the deceased. The treatment was tantamount to a trial of a new medical procedure which, if conducted as such, should have been compliant with ethical medical principles and the medical Code of Professional Conduct. The medical procedures involved fell short of the standards prescribed by Good Manufacturing Practice ("GMP") and the requirements for cellular treatment under the American Association of Blood Banks protocol ("AABB"). Despite its nature and risks involved, CIK treatment was nevertheless marketed by the DR Group through DR Esthetic, the blood was cultured at APSC and the resulting blood product administered to its customers at Mesotherapy, for commercial gain. Accordingly, the prosecution alleged that D1, as the person in charge of the DR Group (who also happened to be a medical practitioner himself) which offered the treatment… [was]…criminally liable for the offence of manslaughter by gross negligence.*"

**Findings of the Inquiry Panel**

9. At the beginning of this inquiry, we allowed the Secretary's application to amend the Notice of Inquiry by deleting in relation to disciplinary charge (a) the allegation that the Defendant has been guilty of misconduct in a professional respect.

10. There is however no dispute that the Defendant was convicted after trial by a jury in Hong Kong of manslaughter, which was at all material times and still is an offence punishable with imprisonment. By virtue of section 21(1)(a) of the Medical Registration Ordinance ("MRO"), Chapter 161, Laws of Hong Kong, our disciplinary powers against the Defendant are engaged.

11. Defence Counsel's submission that "*it is the conviction which forms the sole basis of Complaint [charge] (a) and not the conduct of Dr Chow itself*" is divorced from reality. We appreciate that disciplinary charge (a) has been amended and the Secretary is no longer alleging professional misconduct. It is

nevertheless relevant in our view to look at the conduct of the Defendant, which underlaid his conviction for the offence of manslaughter.

12. Our view is reinforced by section 21(3) of the MRO which provides that:

> "*Nothing in this section shall be deemed to require an inquiry panel to inquire into the question whether the registered medical practitioner was properly convicted but the panel may consider any record of the case in which such conviction was recorded and any other evidence which may be available and is relevant as showing the nature and gravity of the offence*."

13. In this connection, we note from reading the Reasons for Sentence by Mrs Justice BARNES that:-

> "*3. Judging from the jury's verdict, the jury must have found that D1 was a "hands-on-boss", someone in effective control of the DR Group of companies including either all or some of the three limited companies: DR Esthetic Centre (Causeway Bay) Limited, Hong Kong Mesotherapy Centre Limited and Asia Pacific Stem Cell Science Limited, and as such a person in effect control, he was in breach of his duty of care to the deceased* [redacted].
>
> *4. The particulars of breach of duty of care cited against D1 in the indictment were that D1, in the knowledge that the CIK Therapy was based on experimental process for the treatment of cancer and which involved the extraction, manipulation in a laboratory and reintroduction of blood taken from* [redacted]*, (a) failed to ensure a properly qualified person was responsible for the preparation of the CIK blood product; (b) failed to ensure properly validated protocol was in use for the CIK processing, which included the process of sterility test; (c) failed to ensure that sterility test was in fact carried out and documented; (d) failed to have a safe system to ensure that the doctor who administered the blood product to* [redacted] *had checked that sterility test had been conducted and documented; and lastly, (e) failed to fully inform* [redacted] *the risks involved in the administration of the CIK Therapy.*

5. *In finding D1 guilty, the jury must have been satisfied that the breach of duty which they found proved was the cause, or the substantial cause, of the death of* [redacted]. *The evidence showed that* [redacted] *was admitted into the Ruttonjee Hospital on 4 October 2012, the day after she received the CIK infusion. Upon admission* [redacted] *was diagnosed to be suffering from septic shock. The bacteria Mycobacterium Abscessus was found in her blood. The number of bacteria was so abundant that Dr Raymond Liu, the doctor in charge of the ICU at Ruttonjee, described it as "catastrophic". Professor Yuen Kwok Yung, an eminent microbiologist invited by Dr Liu to look at the situation of* [redacted]*, told this court that he had only ever seen one case of such severity: that was in a case of a terminally ill AIDS patient.*

6. *The bacteria in* [redacted] *'s blood were so numerous that they could be detected even before any bacterial culturing was performed.*

7. *Bearing in mind that from the evidence, the culturing of the CIK cells involved the manipulation of the blood in the laboratory of APSC and being kept in incubation at a temperature of 37 degree Celsius for around 15 days, any bacterial contamination, if unchecked or undetected, would result in the bacteria being multiplied to a vast number.*

8. *The evidence before this court, which the jury clearly accepted, was that the contamination of* [redacted] *'s blood product must have occurred at APSC during the culturing process… The breach of duty on the part of D1 resulted in the bacterial contamination not being checked and the heavily contaminated blood product was directly infused into the blood stream of* [redacted]*, causing her to suffer from Mycobacterium Abscessus septicaemia, from which she died due to multi-organ failure.*

9. *The jury's findings also indicated that they were sure that at the time of the breach they found proved, D1 was aware of a serious*

*and obvious risk of death to* [redacted].

*10. Lastly, the jury must have also found that the breach, in all circumstances, were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction. Put differently, the negligence of D1 went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of* [redacted] *as to amount to a crime and deserves punishment.*"

14. In dismissing the Defendant's application for leave to appeal against conviction, the Court of Appeal also had this to say of the Defendant in its Judgment dated 4 November 2021:-

*"134. ...when we examine the part D1 played in the companies concerned, which marketed, prepared and administered the CIK treatment, it becomes obvious that he was involved intimately and personally with them at almost every level of their functions. He was, on the evidence, truly a "hands-on" boss in every respect; and, moreover, on a persistent, regular basis…*

*...*

*137. It was D1's case that he assumed everything was being carried out correctly. But any educated or moderately intelligent person would know, let alone one who is a registered medical practitioner, that one must be exceedingly careful with a blood product so as to ensure it is not contaminated, and to set in place a system designed to ensure its integrity and sterility. Yet APSC had no records, it had no system of checking and cross-checking, there was no SOP designed for the culturing of the CIK blood product in circumstances where D1 acknowledged that the treatment was still experimental: in short, there was no safe system in operation at all. And D1, who was intimately concerned with the marketing, preparation and administration of CIK treatment must have known that. Assumptions that everything is in order are of little relevance where a blood product is concerned; and they*

*are wholly beside the point where there is no safe system employed to deal with it.*

*138. It was the evidence of Professor Yuen…[that]:*

> *"(c) It should also be a very basic and elementary understanding of every medical doctor that any material (such as blood cells) injected or infused into patients must be free of microbes and toxins.*
>
> *(d) The medical doctors involved in this incident should know well that the processed blood cells had been taken out from patients for many days or even weeks for laboratory manipulation before the infusion back into patients. They should be well aware of the obvious risk of microbial (including any bacterial, fungal or mycobacterial) contamination to the processed blood cells which could lead to serious injury or death of a patient receiving infusion. They should therefore only have accepted processed blood cells generated from accredited haematology laboratory supervised by qualified specialist (clinical haematologist). They should also have ensured that the blood cells were free of contaminating microbes by requesting for laboratory reports of microbial culture test done just a few days before the infusion and preferably the report of the gram stain test of the product just before the infusion. Unfortunately, there is no record or indication that they had done the above."*

*...*

*160. However, the background was surely relevant to an assessment of the element of grossness: for example, the fact that the treatment was experimental and unproven, yet was very expensive; the ways in which it was marketed and developed, focusing on particular customers: the "indecent haste" with which it was launched in order to beat a well-known hospital,*

*which was believed to be about to launch CIK treatment itself; and the fact that APSC was being used commercially to generate enormous sums of money for D1 when the government's initiative and true intention behind the use of Science Park was scientific research, were all matters that were part of the background against which to judge whether D1's negligence (which by this stage the jury must have found) was gross. Most evidence called by the prosecution is by its nature prejudicial to an accused person: that does not make it inadmissible. In our judgment, the background was relevant, notwithstanding that the incidents of failure to take reasonable care for the safety of the deceased were in themselves quite appalling, and certainly bad enough to satisfy the test of grossness.*"

15. Our attention was drawn by Defence Counsel to the Court of Appeal's judgment in *Hin Lin Yee v The Medical Council of Hong Kong*; CACV 57/2011; 10 January 2012. We agree with Defence Counsel that we are not bound by the Court of Appeal's view of the evidence or the view of the court below. There must however be cogent evidence upon which we may form a different view.

16. Also, we should give the utmost respect to any observation by the Court of Appeal on the conduct of the Defendant, which underlaid his conviction for the offence of manslaughter.

17. Regrettably, Defence Counsel merely rehearsed before us today some of the appeal submissions, which were roundly rejected by the Court of Appeal.

18. As the Court of Appeal succinctly pointed out in its Judgment dated 23 February 2022:-

"*7. ... Furthermore, it should not be forgotten that there were five allegations of breach of duty dealing with D1's introduction of an experimental and intrinsically dangerous treatment to the market where there was no safe system in existence. Although Mr Harris deftly tried to make the appeal all about the failure to conduct sterility tests, which if they were not being conducted was entirely the fault of D2 and had nothing to do with D1, that*

*was not the limit of the prosecution case. But even if it were, we have already set out our damning conclusions on the evidence as to the grossness of the negligence involved.*"

19. Since the Defendant's application for leave to appeal had already been summarily dismissed by the Court of Final Appeal, we are entitled to take his conviction as conclusively proven against him. Accordingly, we find the Defendant guilty of the amended disciplinary charge (a).

20. With regard to disciplinary charge (b), we bear in mind that the burden of proof is always on the Secretary and the standard of proof for disciplinary proceedings is the preponderance of probabilities.

21. We are unable to agree with Defence Counsel that "*[t]he self-reporting was on 16th January 2018*". The Defendant's application for renewal of annual practising certificate for 2018 was made to the Registrar of Medical Practitioners and not the Council.

22. In our view, Defence Counsel's submission on the delay in reporting being *de minimis* is a non-starter. So is the submission on how the time limit of 28 days should be calculated.

23. We take strong exception to the unfounded defence suggestion that "*bringing* this *complaint [charge (b)] is unnecessary and insensitive*". It was clearly stated in section 29.1 of the Code of Professional Conduct (2016 edition) (the "Code") that "*[f]ailure to report within the specified time will in itself be ground for disciplinary action*". The importance of compliance with the Code was highlighted in Section A (Introduction) of Part I of the Code, which stated *inter alia* that:-

"*The Code embodies two cardinal values of the medical profession. It is committed to maintaining high standards of proper conduct and good practice to fulfill doctors' moral duty of care. Importantly also, the Code upholds a robust professional culture to support self-governing through identifying role-specific obligations and virtues of the medical profession. These obligations and virtues define the moral ethos and shape the professional identity of the medical community. The Code emphasizes that the hallmark of a profession is its distinctive identity and continuous self-development.*

*The Code marks the profession's commitment to integrity, excellence, responsibility, and responsiveness to the changing needs of both patients and the public in Hong Kong.*

*…*

*Contravention of this Code, as well as any written and unwritten rules of the profession, may render a registered medical practitioner liable to disciplinary proceedings.*"

24. Given the nature and gravity of the criminal offence to which his conviction relates, we find it inexcusable for the Defendant not to report it to the Council within the prescribed time limit.

25. In our view, the Defendant's conduct in this regard has fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we also find the Defendant guilty of the amended disciplinary charge (b).

**Sentencing**

26. The Defendant has one previous disciplinary record back in 2002 for not disclosing the relationship with the relevant company or institution when recommending in his column in the Apple Daily certain esthetical products.

27. In line with our published policy, we shall give the Defendant credit in sentencing for not contesting the amended disciplinary charge (a). However, given that there is hardly any room for dispute in a disciplinary case involving criminal conviction, the credit to be given to him must necessarily be of a lesser extent than in other cases.

28. We bear in mind that the primary purpose of a disciplinary order is not to punish the Defendant a second time for the same criminal offence but to protect the public from persons who are unfit to practise medicine and to maintain public confidence in the medical profession by upholding its high standards and good reputation.

29. There is no dispute that the Defendant had committed a very serious criminal offence. The fact that the Defendant was sentenced on appeal to imprisonment for 10 years speaks for itself.

30. Defence counsel submitted that the Defendant did not commit the criminal offence in his capacity as a medical practitioner. This is in our view beside the point. As a registered medical practitioner, the Defendant ought to know better than "*any educated or moderately intelligent person*" that he had introduced "*an experimental and intrinsically dangerous treatment to the market where there was no safe system in existence*".

31. We appreciate that the functions of a criminal court and a disciplinary tribunal are quite different. The focus of a disciplinary tribunal's attention in a case like the present has to be on the need to maintain public confidence in the medical profession; and this is different from that of a criminal court determining sentencing.

32. When considering the appropriate sanction to be imposed on the Defendant in respect of the amended disciplinary charge (a), it is essential in our view to bear in mind the extent to which the Defendant's conviction for the offence of manslaughter is likely to undermine public confidence in the medical profession. Our sanction has to reflect the ethos and expectations of the community at large.

33. Manslaughter is no doubt one of the most serious crimes and the Defendant had brought the medical profession into disrepute and undermined the public confidence in the medical profession. In this connection, we gratefully agree with the following observation by the Court of Appeal in its Judgment dated 4 November 2021:-

> "*160. … the fact that the treatment was experimental and unproven, yet was very expensive; the ways in which it was marketed and developed, focusing on particular customers; the "indecent haste" with which it was launched in order to beat a well-known hospital, which was believed to be about to launch CIK treatment itself; and the fact that APSC was being used commercially to generate enormous sums of money for D1 when the government's initiative and true intention behind the use of Science Park was scientific research, were all matters that were part of the background against which to judge whether D1's negligence (which by this stage the jury must have found) was gross…*"

34. More than 10 years had elapsed since the tragic death of [redacted], we would expect the Defendant to look back and reflect on his wrongdoings. We wish to emphasize that we do not see acceptance of culpability on the part of the Defendant of what he had done as a condition precedent for insight.

35. Regrettably, the Defendant still tried to argue before us today that "*[t]his case was a case where the harm caused was not due to the specific nature of CIK, but to the fact that his specific instructions that sterility testing must be conducted were ignored by his staff*". This reinforces in our view that the Defendant has little or no insight into his wrongdoings.

36. For the protection of members of the public, we cannot safely allow the Defendant to practise medicine.

37. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we shall make a global order in respect of the amended disciplinary charges (a) and (b) that the name of the Defendant be removed from the General Register indefinitely. We also order that the removal order shall take immediate effect upon publication in the Gazette.

Prof. LAU Wan-yee, Joseph, SBS
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong